COLORADO'S KIDS: IMPROVING THEIR HEALTH

22 Recommendations to Improve Medicaid and CHP+

OFFICE OF REP. DIANA DEGETTE

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September 30, 2000

EXECUTIVE SUMMARY

In 1998, over 11 million children in our nation, and over 150,000 in Colorado, remained uninsured despite the passage of the State Children's Health Insurance Program (CHIP or SCHIP) as part of the Balanced Budget Act of 1997 – the largest health expansion for children in 30 years.

The association between improved health and insurance coverage are well documented. This is not just an issue of improved health but one that can save the lives of our nation's children.

Although Colorado is ahead of some states in its implementation of its Children's Basic Health Plan (CBHP), which is otherwise known as Child Health Plan Plus (CHP+), the State has fallen behind a number of other states in getting children the health care coverage they need.

In fact, Colorado was covering 24,410, or approximately 35 percent, of an estimated 69,100 eligible children in its CHP+ program as of April 2000. Of the $41.8 million in Colorado's initial federal allotment for CHIP, the State is expected to return $19 million in unspent funding as of September 30, 2000. It is estimated that between the $19 million in unspent federal funds and the accompanying $10 million in unspent State funds, 29,000 children could have been covered.

[*NOTE: The House Commerce Committee, on which Rep. DeGette serves, has with her support, approved a compromise that would allow states to retain 60 percent of their unspent original CHIP allotment. As a result, Colorado would be allowed to retain $11.5 million of their unspent funds if this proposal becomes law.]*

With regard to federal funding, Colorado has failed to maximize the use of available federal dollars to improve outreach and enrollment efforts.

Furthermore, the State is increasingly criticized for not enrolling more children due to restrictive eligibility standards and bureaucratic barriers to care (e.g., the imposition of a Medicaid assets test, having different definitions between Medicaid and CHP+, a complicated enrollment application, poor coordination between Medicaid and CHP+, etc.).

For example, the Office of the State Auditor has determined that 27 percent of CHP+ funds are spent on administrative costs. Due to federal limits of 10 percent of

administrative expenses, the State presently owes about $2.9 million to HCFA due to draws above the federal limit for administrative costs.

Since the program's inception, Colorado had also imposed both monthly premiums and copayments on families of CHP+ enrollees at levels beginning as low as 100 percent of poverty. As a result, the State had to develop a complex, bureaucratic infrastructure to charge, collect and track monthly family premiums, manage accounts receivable, process numerous changes in enrollment, and transfer premium information between Child Health Advocates (CHA), who administer CHP+, and the State.

This costly and highly bureaucratic premium collection system was shown to reduce the enrollment of children and is being paid with virtually state-only dollars because the State is exceeding the 10 percent federal cap in administrative expenses in CHIP. In addition, for some families, it is more costly to collect the premium than the actual money raised.

Fortunately, Governor Bill Owens has proposed and the Joint Budget Committee (JBC) has supported the elimination of the monthly premium with an annual premium of $25 to $35. This change should increase enrollment and reduce administrative costs.

Improvements to CHP+ should not end here. Governor Owens is correct in saying, "While any new program experiences start-up issues, now that the state has more than two years of experience in operating the program, I think a review of the program is warranted."

What more needs to be done? All efforts must be undertaken to improve both CHP+ and Medicaid. On behalf of Colorado's kids, these programs must work in concert and not in competition.

We also need to give people improved value in the program. For example, the benefits package in Colorado's CHP+ plan is more limited than that provided in other states. In fact, one of the major concerns for working families is affordable dental care for their children. And yet, Colorado is the only state without a dental benefit and has limitations on a number of other benefits for children.

In addition, as policymakers review CHP+ and Medicaid, the State should adopt some common goals for its child health programs, including: (1) improving coverage and child health; (2) removing access barriers to care: (3) reducing bureaucracy and administrative costs; (4) maximizing federal funds; (5) eliminating "welfare stigma" and establishing "personal responsibility"; (6) improving quality of care; and, (7) adopting best practices.

Policies should adhere to these common goals or they should be rejected.

And finally, the State must work to implement policies that may conflict with the goals of the program. For example, Governor Owens was correct in recognizing that the

imposition of monthly premiums was creating significant "unintended consequences" that conflict with important goals of the program, including increasing the number of children covered by the program and operating CHP+ in a fiscally responsible manner. When such a conflict arises, the overriding goal of expanding coverage to children should be preeminent.

With further leadership from the Governor, we can make important strides in the area of improving the health of Colorado's children. Below are recommendations that the State should consider with regard to improving Medicaid and CHP+ for Colorado's kids:

I. COVERAGE AND OUTREACH
1. *Expand Coverage for CHP+ to 200 Percent of Poverty*
2. *Change Age-Based Eligibility Rules*
3. *Adopt 12-Month Continuous Eligibility in Medicaid, As Is Provided for in CHP+*
4. *Adopt Presumptive Eligibility in Medicaid and CHP+, As Is Granted to Pregnant Women in Medicaid*
5. *Improve Outreach Efforts, Including Spending the $5 Million in TANF Outreach Dollars on Medicaid and CHP+*
6. *Do Not Eliminate CICP for Children*

II. ENROLLMENT BARRIERS
1. *Inform Families About Change in CHP+ Premium Structure*
2. *Eliminate the Medicaid Assets Test*
3. *Create a Single Definition of "Family Income"*
4. *Simplify the Medicaid and CHP+ Application and Enrollment Processes*
5. *Simplify Redetermination Procedures in Medicaid and CHP+*
6. *Reduce the Waiting Time That It Takes to Get Children Covered*
7. *Reduce or Eliminate Verification and Documentation Requirements*

III. HEALTH BENEFITS
1. *Add a Dental Benefit to CHP+*
2. *Improve Other CHP+ Benefits*

IV. PROGRAM EFFICIENCY AND COORDINATION
1. *Improve Coordination Between All Children's Health Programs*
2. *Reduce Administrative Costs*
3. *Move Medicaid Eligibility Determination Out Into the Communities*
4. *Maximize Federal Funding and Improve State-Federal Relations*

V. QUALITY AND ACCESS TO CARE
1. *Improve Cultural Competency*
2. *Recruit and Adequately Reimburse Providers to Improve Access to Care for Children*
3. *Adopt Child-Specific Protections and Quality Standards*

COLORADO'S KIDS:
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The Importance of Health Coverage for Children

In 1998, over 11 million children in our nation, and over 150,000 in Colorado, remained uninsured despite the passage of the State Children's Health Insurance Program (CHIP or SCHIP) as part of the Balanced Budget Act of 1997 – the largest health expansion for children in over 30 years.

According to a study by the Commonwealth Fund, approximately five million of these children are eligible but unenrolled in the Medicaid program and another four million could be covered by CHIP. Together, Medicaid and CHIP could cover up to nine million, or 80 percent, of the uninsured children in the country.[1]

The association between improved health and insurance coverage are well documented for children. Numerous studies have demonstrated that health insurance coverage increases children's access to preventive, primary, and acute care.[2]

As the American College of Physicians-American Society of Internal Medicine has found, "A lack of insurance for children has serious consequences. . . ."[3]

Uninsured children, compared with the insured, are:

- Up to 6 times more likely to have gone without needed medical, dental, or other health care
- 2 times more likely to have gone without a physician visit during the previous year
- Up to 4 times more likely to have delayed seeking care
- Up to 10 times less likely to have a regular source of care
- 1.7 times less likely to receive medical treatment for asthma
- Up to 30% less likely to receive medical attention for any injury[4]

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[1] Thorpe, Kenneth, and Curtis Florence, "Covering Uninsured Children and Their Parents," The Commonwealth Fund, July 1998, http://www.cmwf.org/programs/insurance/thorpe275.asp.

[2] American College of Physicians-American Society of Internal Medicine (ACP-ASIM), *No Health Insurance? It's Enough to Make You Sick*, November 1999; General Accounting Office, *Health Insurance: Coverage Leads to Increased Health Care Access for Children*. GAO/HEHS-98-14, November 1997. These reports are comprehensive reviews of numerous studies that document the importance of health insurance coverage for children.

[3] ACP-ASIM, p. 18.

[4] ACP-ASIM, pp. 18-20.

This is equally true of expanded coverage in government health programs. In fact, one study has "estimated that the 15 percent rise in the number of children eligible for Medicaid between 1984 and 1992 decreased child mortality by 5 percent."[5]

As a result, this is not just an issue of improved health but one that can save the lives of our nation's children.

Where We Stand

After the passage of the CHIP by the federal government in the fall of 1997, which provides $40 billion to states for the purpose of expanding children's health coverage over a 10-year period, states have three options for structuring their CHIP programs: (1) enact a Medicaid expansion; (2) establish a separate state health insurance program; or, (3) use a combination of these two approaches.

Colorado was the first state to gain approval for a non-Medicaid expansion, or separate state health program, called the "Children's Basic Health Plan" (CBHP) from the Health Care Financing Administration in February 1998 – 2 ½ years ago.[6] CBHP has been marketed to the public under the name "Child Health Plan Plus" (CHP+).

Colorado has received three federal awards through the federal CHIP program thus far:

$41.8 million, available through September 30, 2000.
$41.6 million, available through September 30, 2001.
$46.9 million, available through September 30, 2002.

"While any new program experiences start-up issues, now that the state has more than two years of experience in operating the program, I think a review of the program is warranted."

-- Governor Bill Owens
July 28, 2000

Although Colorado is certainly ahead of many states in moving forward with its health plan to expand coverage to children (e.g., Wyoming and Washington received final approval for their CHIP plans in September 1999[7]), the State has fallen behind a number of other states in getting children the health care coverage they need.

- ***Inadequate Enrollment:*** According to the State Auditor, Colorado will be returning $19 million in unspent federal CHIP funds because of poorer than expected

[5] General Accounting Office, November 1997, p. 22; Currie, J., and Jonathan Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," *Quarterly Journal of Economics*, Vol. 111, No. 2, (1996), pp. 431-466.

[6] Office of the State Auditor, State of Colorado, *Report of the State Auditor: Children's Basic Health Plan,* Department of Health Care Policy and Financing, Performance Audit, July 2000, p. 21.

[7] U.S. Department of Health and Human Services, "CHIP Program Now Approved in All States and U.S. Territories," Press Release, September 8, 1999.

enrollment.[8] Of the estimated 69,100 children eligible for this program, only 24,410, or 35 percent, have been enrolled as of April 2000. As a result, Colorado will return almost 46 percent of its first federal award.[9] This funding, including the set-aside state funding that will go unspent, could have provided health coverage to an estimated 29,000 children.[10]

[NOTE: The House Commerce Committee, on which Rep. DeGette serves, has with her support, approved a compromise that would allow states to retain 60 percent of their unspent original CHIP allotment. As a result, Colorado would be allowed to retain $11.5 million of their unspent funds if this proposal becomes law.][11]

This is occurring in part because, as the *Denver Post* notes, "Eligibility is rigid. Most states accept families at 200 percent or 300 percent of poverty level. CHP+ only admits at up to 185 percent."[12] The *Post* adds*, "*And it is one of the least effective, enrolling just one-third of eligible children."[13]

In fact, 29 states, including New Mexico, have expanded health care coverage for children up to 200 percent or above.

Moreover, rather than returning millions of dollars to the federal government as Colorado is preparing to do due to restrictive eligibility and poor enrollment, 13 states have spent their first award grants and are already into, or moving into, their second year of funding.

On the other hand, a number of states, including Texas and California, are behind Colorado's enrollment pace. For example, Texas and California are scheduled to give up over 70 percent of their initial awards due to slow start-up problems (e.g., Texas did not enact a CHIP law until mid-1999, more than 18 months after the federal program was created and over a year after Colorado had received approval

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[8] The Congress is currently considering legislation that would allow states that have unspent CHIP allotments to keep 60 percent of those funds for two additional years. As a result, Colorado would be allowed to keep $11.5 million of its unspent FY 1998 CHIP allotment if that legislation passes this legislative session.

[9] Office of the State Auditor, p. 2.

[10] The Office of the State Auditor says that $10.1 million of State general funds will go unspent in addition to the $19.1 million in federal funds that the State is "slated for reversion" (p. 2). Assuming a average cost at slightly over $814 per child for FY 2000 (p. 15), this estimate of 29,000 children not receiving coverage is rather conservative.

[11] McAllister, Bill, "Bill in Congress Would Save State's Child-Health Funds," *Denver Post*, September 28, 2000; and, Jessica Wehrman, "House Panel Backs Kids' Health Funds," *Denver Rocky Mountain News*, September 28, 2000.

[12] "Kids' Health Betrayed," *Denver Post*, Editorial, July 3, 2000.

[13] "Righting CHP+ Wrongs," *Denver Post*, Editorial, August 6, 2000.

from the federal government to begin its program) and other enrollment barriers those two states have imposed.[14]

Regardless, we should not accept being a "middle-of-the-pack" state. Colorado can and must do better on behalf of its children.

- ***High Administrative Costs:*** For fiscal year (FY) 2000, the State Auditor has found that 27 percent of CHP+ funds are spent on administrative costs. Federal law limits administrative expenses to 10 percent of the program so the additional 17 percent comes entirely out of state funds. Presently, the State owes about $2.9 million to HCFA due to draws above the federal limit for administrative costs.[15]

  Administrative costs and oversight in CHBP/CHP+ include:

  1) the Department of Health Care Policy and Financing (HCPF), which oversees Medicaid, CHBP/CHP+, and the Colorado Indigent Care Program (CICP);
  2) Child Health Advocates (CHA), which is the private administrative contractor for CHBP/CHP+;
  3) HMO's, which receive capitated payments for children enrolled in their health plan[16];
  4) CHBP Network, which are fee-for-service providers outside the HMO networks;
  5) Anthem (formerly Blue Cross/Blue Shield of Colorado), which oversees the claims processing to providers under in the CBHP Network;
  6) Horizon Behavioral Services, which provides mental health services and claims processing for CBHP/CHP+;
  7) U.S. Benefits, which provides reinsurance for catastrophic claims in CBHP/CHP+;
  8) the CBHP Policy Board, which establishes policies and rules for CBHP/CHP+;
  9) the CHA Board of Trustees;[17] and,
  10) a new Task Force recently established by the Governor.[18]

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[14] Nolan, Chris, "State to Lose Billions for Children's Health," *Stateline.org*, June 29, 2000, http://www.stateline.org/story.cfm?storyid=83726.; Dorsey Griffith, "State to Lose $590 Million to Ensure Kids: Unused Funds Forfeit in 6 Weeks," *Sacramento Bee*, August 19, 2000; David Crowder, "City Urges Action on CHIP," *El Paso Times*, June 26, 2000.

[15] Office of the State Auditor, pp. 24-28. *NOTE: Of the $16.2 million spent in FY 2000 for the Children's Basic Health Plan, almost $6 million were in administrative costs.*

[16] *NOTE: The administrative costs expended by HMO's are not reflected in the administrative costs of the program as they are folded into the capitation rate paid to HMO's. As a result, the overall administrative costs of the program are unlikely underestimated at 27 percent.*

[17] Office of the State Auditor, p. 23.

[18] Crowder, Carla, "State Health Plan for Poor Blasted," *Denver Rocky Mountain News*, August 1, 2000.

In sharp comparison, other government health care programs, such as Medicaid, Medicare, and the Federal Employees Health Benefits Program (FEHBP) have administrative costs that are far less than five percent.

- ***Premiums – Important Improvements Being Made:*** Governor Owens has announced that: (1) back payments of past premiums owed by families with children enrolled in CHP+ will be cancelled; (2) he would seek legislative approval to stop charging monthly premiums altogether through the end of the year; and, (3) he will seek to replace the monthly premium, which charges some families up to $360 per year, with a flat, annual fee of $25 to $35 per family.[19]

  As Governor Owens said, "We're going to step away from the mistakes that were made in the past and move to a system that is much better at providing what everybody wants to see – a better plan to insure Colorado's children."[20] This plan received approval by the legislature's Joint Budget Committee on September 20, 2000.

  > "*We're going to step away from the mistakes that were made in the past and move to a system that is much better at providing what everybody wants to see – a better plan to insure Colorado's children."*
  >
  > -- Governor Bill Owens
  > August 23, 2000

  Prior to the change, CHP+ was, according to the *Denver Post*, "the fifth most expensive such program in the nation, charging poor parents up to $30 a month plus co-payments."[21] Rather than $30 per month, the change initiated by Governor Owens eliminates the monthly premium and replaces it with an annual premium of between $25 and $35.

  This change is significant because Colorado has had to develop an administratively complex, bureaucratic infrastructure to charge, collect and track monthly family premiums, manage accounts receivable, process numerous changes in enrollment, and transfer premium information between CHA and the State.

  As a result, the costs of collecting these premiums appeared to be more than the money that was raised.[22] According to the *Denver Rocky Mountain News*, "The state pays a private contractor millions to collect these premiums. . . Critics of the

[19] Auge, Karen, "Owens Cancels Needy-Child Insurance Debt," *Denver Post*, August 23, 2000.

[20]; Sanko, John, "Poor Families to Get Help for Insurance: Owens Wants Payment Slashed for Kids' Health," *Denver Rocky Mountain News*, August 23, 2000.

[21] "Righting CHP+ Wrongs," August 6, 2000.

[22] Crowder, Carla, "Health Plan Recruits Children: Complicated Rules, High Premiums Place Barricades Before Poor," *Denver Rocky Mountain News*, July 10, 2000.

setup say Colorado is wasting money enforcing its stringent rules while thousands of uninsured children fall by the wayside."[23]

Furthermore, this costly and highly bureaucratic premium collection system was being paid with virtually state-only dollars because the State has been exceeding the 10 percent federal cap in administrative expenses for CHIP.

While increasing state spending due to bureaucracy, the premium system also minimized federal funding. According to the State Auditor, "Premium revenues. . .are deducted from benefit costs, thereby decreasing the amount of costs against which the administrative limit is calculated. This means premium revenues have the effect of decreasing the amount of dollars allowable for administration for which federal matching funds can be obtained."[24]

The Owens initiative is even more important because premiums have been shown in numerous studies to reduce enrollment and impose extra barriers to health coverage for families.

A report by Health Management Associates and the Lewin Group indicates, ". . .both premiums and copayments introduce new complexity into program administration. Premium-sharing, in particular, may provide disincentives for enrollment – even at quite low levels. It can also create logistical difficulties for families in arranging monthly payments. . .As a result, premiums affect both the initial decision to enroll as well the decision to remain in the program." [25]

- ***Limited CHP+ Benefits:*** Colorado is the only state in the nation to not provide a dental benefit to children in CHIP.

  The National Center for Health Statistics reported that dental care was the common unmet need for all children – but "uninsured children were more than three times as likely not to receive needed dental care as children who had publicly funded insurance. Almost 16 percent of uninsured children were reported as needing but not receiving dental care."[26]

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[23] Crowder, Carla, "Children Exposed: Few Parents Sign On To Costly, Cumbersome State Health Insurance," *Denver Rocky Mountain News*, July 17, 2000.

[24] Office of the State Auditor, p. 43.

[25] O'Brien, Mary Jo, and Meghan Archdeacon, et al, "State Experiences With Cost-Sharing Mechanisms in Children's Health Insurance Expansions," Report by Health Management Associates and the Lewin Group and published by the Commonwealth Fund, May 2000.

[26] General Accounting Office, *Health Insurance Coverage Leads to Increased Health Care Access for Children*, pp. 20-21.

Even if Colorado's low-income kids are covered by Medicaid or CHP+, they have limited access in Medicaid due to poor provider reimbursement rates and have no dental benefit at all in CHP+.

Moreover, with respect to other benefits in CHP+ such as prescription drugs, vision, mental health, and hearing, Colorado has service limits on all four of these important benefits.[27]

- ***Medicaid Assets Test – Imposes Additional Barriers to Care:*** Colorado is also one of just six states in the country that maintains an assets test in its Medicaid program (and it is one of the most stringent). This causes the application form to be more complicated and cumbersome. As a result, it acts as yet another barrier to care.

  During 1999, the Denver Department of Human Services received 15,330 applications for Medicaid and 3,700 were denied for having an asset, such as a car. As the *Denver Post* notes, "Acquire an asset worth more than [$2,500] – such as a car – and you've traded in health insurance for your children."[28] David Osbourne, author of *Reinventing Government*, would argue against this structure because it penalizes success.[29]

  Furthermore, after being denied Medicaid, some families fall through the cracks and remain uninsured while others are subsequently enrolled in CHP+. The result is that 32 percent of CHP+ enrollees have income below 100 percent of poverty.[30]

  In other words, CHP+ is drawing a high percentage of extremely low-income people that would otherwise be eligible for Medicaid if not for the assets test. As a result, these low-income families are subjected to a reduced benefits package in CHP+. This is particularly problematic for children with special health care needs, as there are limited benefits for durable medical equipment, physical therapy, occupational therapy, and speech therapy, among others, in CHP+.[31]

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[27] General Accounting Office*, Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits,* GAO/HEHS-00-86, April 2000, pp. 24-26.

[28] Kreck, Carol, "Barriers Against Children's Health: Many Kids in Poverty Drop Through Holes in State's Poorly Funded Medical Programs," *Denver Post*, February 15, 2000.

[29] Osbourne, David, and Ted Gabler, *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector*, 1992, p. 149.

[30] Department of Health Care Policy and Financing, State of Colorado, "Colorado Children's Basic Health Plan Family Premium Structure: A Report to the Joint Budget Committee," December 1999.

[31] "Minutes of the Children's Basic Health Plan Policy Board Meeting," Department of Health Care Policy and Financing, January 4, 2000, p. 4.

Furthermore, children do not have the important managed care patient protections in CHP+ that are present in the Medicaid program.[32]

For example, in Medicaid, health plans must have capacity standards for specialists to whom children with special health care needs have direct access or can use as primary care physicians. Children with special needs must receive a needs assessment and subsequent treatment plan, along with case management services. Furthermore, access to specialists and to services, quality of care, coordination of care, enrollee satisfaction, Americans with Disabilities Act access standards, the application of a medical necessity standard are all monitored in Medicaid.[33] Such protections are not in place for children in CHP+.

- ***Leaving Outreach Funds Unspent and Inappropriately Dropped Eligible Children from Medicaid when Their Families Leave Welfare:*** As part of welfare reform and the creation of Temporary Assistance for Needy Families (TANF), states were also provided $500 million for the purposes of initiating outreach efforts to families that may go off of welfare but would still be eligible for Medicaid or CHIP. That funding was to expire in October 1999, but a provision from H.R. 827, the "Improved Maternal and Children's Health Coverage Act"[34] was adopted in the Balanced Budget Refinement Act (BBRA)[35] last year to extend the deadline permanently.

  Despite the extension (which saved Colorado from losing almost $5 million in federal outreach funds) and up to a 90 percent federal matching rate (depending on the outreach activity and allotment spending),[36] 93 percent of Colorado's $5.2 million

[32] The Colorado Medicaid program participates in the Consumer Assessment of Health Plans Study (CAHPS), has created the Safety Net Project (which is described as a safety net for children and youth with special needs enrolled in Medicaid), must abide by federal managed care protections and guidance (which includes addressing particular issues for children with special health care needs), etc.

[33] General Accounting Office, *Medicaid Managed Care: Challenges in Implementing Safeguards for Children with Special Needs,* GAO/HEHS-00-37, March 2000.

[34] DeGette, Diana, U.S. House of Representatives, "Improved Maternal and Children's Health Coverage Act" (H.R. 827), 106th Congress, February 24, 1999. *In addition, the legislation, if enacted in its entirety, would: (1) streamline the enrollment process so families will have a simplified application and enrollment process in Medicaid and CHIP; (2) provide states will additional resources to be more creative about education families and eliminating barriers that prevent children from receiving coverage; and, (3) broaden states' flexibility so that they can use CHIP funding to cover pregnant women, which reduces infant mortality and improves child health as well, and legal immigrant children and pregnant women*.

[35] The Balanced Budget Refinement Act (BBRA) was incorporated by reference into Public Law 106-113, the Consolidated Appropriations Act for FY 2000.

[36] Examples of activities matched at 90 percent include public service announcements, placement of eligibility workers in new locations, and development and dissemination of new publications for at-risk populations. Activities that may be matched at either 90 percent or 75 percent (depending on whether claims are made against the base or secondary allocation, respectively) include designing new eligibility forms and eligibility system changes.

allotment for health care outreach in Medicaid and CHP+ had been left unspent as of December 1999.[37] Although the money has been obligated at a more rapid pace this year, over $3 million remained unspent and over $600,000 remained unobligated as of June 22, 2000.[38]

Some at the state level have argued that federal rules prevent Colorado from using the $5.2 million in outreach funding for CHP+ and that the funds are restricted to Medicaid only. However, repeated guidance from the federal level indicates that the funds *may be used for both Medicaid and CHP*+ (although the federal government would not support allowing the funds to be spent on CHIP outreach to the exclusion of Medicaid).

As long ago as June 5, 1998, states received guidance from the federal government stating, "We urge you to make TANF a part of your Medicaid and CHIP outreach strategy. . .Families who inquire about or apply for TANF should also receive information about Medicaid and CHIP, how to apply for these programs, and how to receive assistance with the applications. . .We strongly encourage you to ensure that [state] workers receive support in learning about your State's Medicaid and CHIP programs and understand that securing health insurance through CHIP or Medicaid is a high priority of TANF agencies."[39]

The State of Pennsylvania, for example, is using its share of the $500 million fund in "developing a common Medicaid/CHIP application" and other joint Medicaid and CHIP outreach activities.[40]

Furthermore, Colorado has inappropriately dropped families leaving welfare from continuing to receive Medicaid coverage. According to *Denver Rocky Mountain News* reporter Carla Crowder, ". . .Colorado counties mistakenly kicked thousands of needy children off Medicaid when their parents' welfare cases were closed because of welfare reform. The families were supposed to keep receiving Medicaid, but untrained caseworkers with outdated computers simultaneously closed both

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[37] Nolan, Chris, "Millions to Ensure Health Coverage for Poor Go Unspent," *Stateline.org*, June 15, 2000, http://www.stateline.org/story.cfm?storyid=81725; see also, Robert Pear, "Cash to Ensure Health Coverage for the Poor Goes Unused," *New York Times*, May 21, 2000.

[38] Golden, Marlyn, "Memorandum to Jim Rizzuto and Alexis Senger," Department of Health Care Policy and Financing, July 5, 2000.

[39] Golden, Olivia, and Nancy-Ann Min DeParle, "Letter to State Medicaid Directors and TANF Administrators," Administration for Children and Families and the Health Care Financing Administration, U.S. Department of Health and Human Services, June 5, 1998, http://www.hcfa.gov/medicaid/wrdl1605.htm. In addition, see U.S. Department of Health and Human Services, *Report to the President on School-Based Outreach for Children's Health Coverage*, July 2000, p. 13.

[40] Ross, Donna Cohen, "Sources of Federal Funding for Children's Health Insurance Outreach," Center on Budget and Policy Priorities, February 17, 2000, http://www.cbpp.org/2-17-00health.htm, p. 2.

benefits. Now the state is scrambling to find those families under threat of a lawsuit."[41]

According to an analysis of data from Colorado's "leaver" study (which tracks how former welfare recipients are faring), ". . .in Colorado, 90 percent of children who were uninsured some two years after leaving welfare remained eligible for health coverage and could have been enrolled in Medicaid or the state's separate SCHIP program. Had the eligible children in Colorado remained on Medicaid or received coverage through the state's SCHIP program, only two percent of children in families that left welfare would have become uninsured. As it was, nearly one in three – 31 percent – were uninsured."[42]

Again, the State may use their unspent $5 million in federal outreach funds for this purpose.

And finally, once the $5 million in outreach funds are eventually spent, there are a number of other federal funding opportunities for states to use in order to improve outreach and enrollment efforts. For example, the U.S. Department of Health and Human Services has issued separate guidance that explicitly notes that TANF and TANF maintenance of effort (MOE) funds may be used for SCHIP outreach efforts. As that guidance reads:

> *Question: "Are costs associated with SCHIP outreach administrative costs?"*
>
> *Answer: "As the TANF funding guide indicates, States may use TANF and MOE funds for SCHIP outreach activities that will improve access of needy families to SCHIP benefits. Any such expenditures by a State would not count against its administrative cost caps. The final rule. . .cites the example of providing program information as example of an activity that is excluded from the definition of administrative costs. Similarly, we would exclude the cost of providing information to needy families about related services or programs for which they might be eligible."*[43]

Again, despite the claims of some state officials, the guidance is clear. TANF and MOE funds can be used for CHIP outreach activities and are being underutilized by

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[41] Crowder, Carla, "Health Plan Recruits Children: Complicated Rules, High Premiums Place Barricades Before Poor." See also, Rachel Benson Gold, "Implications for Family Planning of Post-Welfare Reform Insurance Trends," *The Guttmacher Report on Public Policy*, December 1999, pp. 6-9. This study indicates, "The proportion of women of reproductive age covered by Medicaid fell from 12.6% in 1994 to only 9.9% in 1998, a 21% decrease." In Colorado, the percentages were 6.4% in 1994 and 3.2% in 1998, a 50% decrease.

[42] Guyer, Jocelyn, and John Springer, "Health Care After Welfare: An Update of Findings from State-Level Leaver Studies," Executive Summary, Center on Budget and Policy Priorities, August 6, 2000.

[43] Administration for Children and Families (ACF), U.S. Department of Health and Human Services, "Use of Funds," http://www.acf.dhhs.gov/programs/ofa/polquest/usefunds.htm.

Colorado. Undertaking such actions would help Colorado address its problem of exceeding the 10 percent administrative cap in CHIP. As the Center on Budget and Policy Priorities says, ". . .if a state wants to conduct outreach for a CHIP-funded separate program, but has reached its cap on CHIP administrative funds, it may conclude that use of TANF or MOE funds is worthwhile."[44]

In an analysis of unspent TANF funds, it is estimated that Colorado had $109.3 million in unspent TANF funds (both unobligated funds and unliquidated obligations) as of March 31, 2000.[45]

Furthermore, states can also shift some administrative costs from CHIP plans to Medicaid. As the Congressional Research Service points out, "The current law allows flexibility in seeking federal payments for expenditures associated with outreach for SCHIP. For states that expand Medicaid under SCHIP, federal financial participation for related administration and outreach expenditures may be claimed either through Medicaid or SCHIP."[46] Colorado could expand Medicaid up to 19 years of age at 100 percent of poverty immediately, receive the enhanced federal matching rate, and shift some administrative costs to Medicaid, but instead, has chosen to be one of only a few states not to do so.[47]

The State's reluctance to use these options appears to stem from a desire to limit enrollment in the Medicaid program. As was reported to the General Accounting Office, "Among the states able to provide amounts for both programs, two states indicated that more was allocated or spent for SCHIP outreach than for Medicaid outreach. For example, Colorado estimated $10,000 in Medicaid outreach funds and about $700,000 budgeted for SCHIP. In contrast, Utah reported more spending for Medicaid outreach ($716,000) than for SCHIP ($50,000).[48]

This desire is costing the State money and is limiting the enrollment of uninsured children, particularly the poorest and most vulnerable children in Colorado.

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[44] Ross, Donna Cohen, "Sources of Federal Funding for Children's Health Insurance Outreach," p. 5.

[45] Lazere, Ed, "Unspent TANF Funds in the Middle of Federal Fiscal Year 2000," Center on Budget and Policy Priorities, August 2, 2000, p. 10 (see Table III).

[46] Congressional Research Service*, Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?*, May 1, 2000, p. 16.

[47] The Baby Care/Kid Care Medicaid covers children from 0-5 years of age up to 133 percent of poverty. The regular Medicaid program covers children from 6-16 years of age up to 100 percent of poverty. Adolescents who are 17 and 18 years of age are covered up to 38 percent of poverty, although that will change due to federal law ("Waxman kids") which requires those children to be covered up to 100 percent of poverty by 2002. CHP+ and CICP provide an overlay of coverage up to 185 percent of poverty for children up to age 19. See, for example, Table 12 in Office of the State Auditor, p. 87.

[48] General Accounting Office*, Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits*, p. 8.

- ***Complicated Application and Enrollment Process:*** Due to the assets test for Medicaid, different definitions of items such as "family income" between Medicaid and CHP+, language barriers, poor coordination between Medicaid and CHP+, and other concerns, the application and enrollment process in Colorado is a difficult maze and often results in delayed coverage or even unresolved disposition of applications.

  For example, the application is cumbersome and extremely difficult to fill out. It includes everything from reporting whether anyone in the household has any resources such as a checking account, life insurance, burial insurance, a savings account, or any personal item over $1,000 (which is difficult to determine) to documenting things such as work income, alimony, child support, interest from savings, CD's, etc. for "this month and 3 months prior."[49]

  The application also fails to fully address language and cultural barriers. As one report notes, "In Colorado, respondents reported that many potential enrollees, particularly Hispanics, find that materials and marketing messages are unclear. Translations from English to Spanish are reportedly done in a strictly literal, word-for-word fashion, rendering many of them inadequate."[50]

  For those that do attempt to fill out the application, the *Denver Post* reports that, due to complications with the application form, ". . .37 percent of all families denied CHP+ coverage are turned down because their application was incomplete."[51]

  Meanwhile, there are a number of people that receive the application and never submit it. For example, the complicated application creates a final barrier at the end with a note next to the signature line that threatens:

  > *"By signing this form, I certify that the information I have given is true. I know it is a crime to knowingly get money or benefits I should not get. I know that crime is*

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[49] Department of Health Care Policy and Financing, State of Colorado, "Application for Colorado Health Care," 395-80-93-0210 (R 11/98).

[50] O'Brien, Mary Jo, and Meghan Archdeacon, et al, "State Experiences With Access Issues Under Children's Health Insurance Expansions," Report by Health Management Associates and the Lewin Group and published by the Commonwealth Fund, May 2000.

According to an article by Carla Crowder of the Denver Rocky Mountain News entitled "Health Plan Recruits Children: Complicated Rules, High Premiums Place Barricades Before Poor": ". . .Spanish-language versions of one of the CHIP rules translated premium as 'prima,' which means female cousin to most Spanish speakers. Clients were warned that if they failed to pay their cousin, they could lose coverage."

[51] Auge, Karen, "Kids' Health Plan Ailing," *Denver Post*, September 24, 2000.

punishable by a fine of up to $20,000 or a jail term of up to 16-32 years or both" [emphasis added].[52]

This threat undoubtedly limits enrollment as some families choose not to enroll in the face of this rather substantial threat. If a goal is to adopt a "commercial model," this is clearly not it.

In sharp comparison, other states have far shorter and less complicated forms. For example, as reported by *Stateline.org*, "Florida, North Carolina, Indiana, Illinois, Connecticut, New Hampshire, California, New Jersey and New York have all reduced or simplified their CHIP applications process. California, for example, cut its application form from 28 pages to four."[53]

Finally, even for families that do manage to fill out the application, children and their families often go months awaiting a disposition on their applications and sometimes never even obtain a final determination from either Medicaid or CHP+.[54]

- ***Poor Coordination Between Medicaid and CHP+:*** According to the State Auditor, ". . .state statutes for CBHP indicate that identifying and addressing opportunities for interprogram communication, coordination, and consolidation are all viewed as important aspects of implementing the program."[55]

  Despite this, entry points or locations where families can actually enroll in the programs are different for each program. The eligibility systems for CBHP/CHP+, Medicaid and CICP often do not interact or exchange information.

  Poor coordination is a tremendous problem in Colorado.

  As the State Auditor has found:

  "All three programs (CBHP/CHP+, Medicaid, and CICP) have different eligibility and enrollment systems, benefits, cost sharing arrangements, and requirements."[56]

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[52] Department of Health Care Policy and Financing, State of Colorado, "Application for Colorado Health Care."

[53] Cosgrove, Maureen, "States Experiment With CHIP Outreach Methods," *Stateline.org*, August 8, 2000, http://www.stateline.org/story.cfm?storyid=88525.

[54] Crowder, Carla, "Families Struggle for Coverage," *Denver Rocky Mountain News*, July 17, 2000.

[55] Office of the State Auditor, p. 83.

[56] Office of the State Auditor, p. 5.

"Lack of adequate communication between CBHP and Medicaid eligibility systems can cause processing delays for applicants referred to the other program. From mid-February to mid-March 2000, CHA sent the counties applications for 536 children who appeared Medicaid-eligible. By late April, CHA has received dispositions from the counties for only 144 of the children, or about 27 percent. . .For the remaining 392 children (73 percent), we tested a sample of 27 applicants and were only able to determine that 15 of these had been enrolled in Medicaid."[57]

"Staff report that there can be substantial delays in hearing back from the counties, and in some cases the disposition is never received."[58]

"The Medicaid program does not have processes in place to ensure that families receive information about CHP+ if they are determined ineligible for Medicaid or disenrolled from Medicaid programs due to lack of continued eligibility. . .We identified enrollment errors related to CBHP children simultaneously enrolled in Medicaid that were as much as 12 months old."[59]

"Families disenrolled from Medicaid programs may not always be referred to or receive information about CBHP. . .If the family submits the redetermination form and is found ineligible for Medicaid, the county does not forward information to CBHP, because the redetermination form is not designed so that it can be used as a referral form to CBHP. . .Additionally, the Medicaid 'denial' letter that is automatically sent to families informing them that they are no longer eligible for the Medicaid program does not inform families that their children may be eligible for CBHP or tell them how to apply for the program."[60]

"Controls over retroactive enrollment adjustments are particularly important because CBHP children are sometimes simultaneously enrolled in the Medicaid program ('dual-enrolled'). . .Currently there is no routine exchange of information between the CBHP and Medicaid databases to systematically identify and correct instances of dual enrollment between these programs. . .Double payment of health care coverage is a poor use of funds . . . ."[61]

Children and their families are often the ones harmed by these failures.

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[57] Office of the State Auditor, pp. 5, 93.

[58] Office of the State Auditor, p. 93.

[59] Office of the State Auditor, pp. 5, 65.

[60] Office of the State Auditor, pp. 95-96.

[61] Office of the State Auditor, pp. 67-68.

- ***Dedicated People Trying to Overcome Fundamental Design Problems:*** At every level, people that are working on Medicaid and CHP+ are working hard to overcome fundamental problems in the design of the program and difficulties that arise in attempting to address conflicting goals.

  For example, staff at HCPF, CHA and the CBHP Policy Board spent much of the end of last year and the early part of this year attempting to address the desire to get children covered with health insurance coverage as early as possible, on the one hand, and the desire to enroll these families in managed care, on the other hand.

  Although some raised the possibility of eliminating the pre-enrollment period from CHP+, which allows children to be covered for that period between their application and subsequent enrollment in CHP+ and in a managed care plan, a number of people worked hard in opposition to the elimination of the pre-enrollment period.

  As was argued at a CBHP Board meeting, ". . .the pre-enrollment period provides a critical incentive to patients and providers. If this period is eliminated, providers who take applications won't get paid, and it may be a disincentive for families who know that they can't access care during that period."[62]

  HCPF, CHA and the CBHP Policy Board invested time and research into the pros and cons of the pre-enrollment period. CHA, for example, estimated that there would be a 20 percent decrease in enrollment if the pre-enrollment period was discontinued. There was also much discussion by CBHP Board members, such as Board Chairman Bill Lindsay and Children's Hospital CEO Dori Biester, about the "impact on the children who [would] not get needed health care."[63]

  The Board then met with members of the Joint Budget Committee (JBC), who understood the importance of maintaining the pre-enrollment period. Legislation was subsequently drafted and passed (Senate Bill 00-223) that protected and codified the pre-enrollment period into law.[64]

  Unfortunately, while other problems that have been raised such as frustration with the premium structure and poor enrollment have been met with a great deal of time and energy as well, state officials and advocates for CHP+ are often forced to apply "band-aid" temporary fixes to fundamental problems with the design of the program.

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[62] "Minutes of the Children's Basic Health Plan Policy Board Meeting," Department of Health Care Policy and Financing, January 4, 2000, p. 6.

[63] "Minutes of the Children's Basic Health Plan Policy Board Meeting," Department of Health Care Policy and Financing, February 1, 2000, p. 4.

[64] "Minutes of the Children's Basic Health Plan Policy Board Meeting," Department of Health Care Policy and Financing, March 7, 2000, p. 3; "Minutes of the Children's Basic Health Plan Policy Board Meeting," Department of Health Care Policy and Financing, July 11, 2000, p. 3.

Prior to the change in the premium structure initiated by Governor Owens, the CBHP Policy Board heard extensive presentations of problems with the imposition of premiums on families, including:

(1) the premium structure "is in conflict with the intent to get maximum enrollment in the program"[65];
(2) findings of a study indicated that families with income up to 185 percent of poverty, the maximum coverage point in CHP+, are "likely to have little or nothing to spend on health insurance after spending income on 'essentials'"[66];
(3) studies of people that disenrolled from CHP+ that cited premiums as a reason for disenrollment[67];
(4) problems of risk selection and reduced continuity of care (i.e., healthy people would opt out and only sick people would have an incentive to pay) due the premium[68];
(5) poor enrollment (36-39%) among families that have to pay a premium[69];
(6) studies that indicated 80% of the states do not charge premiums to families below 150 percent of poverty – unlike Colorado[70];
(7) the problem caused by imposing a premium on low-income populations below 133 percent of poverty, as Colorado does, that creates an inequity between CHP+ and Medicaid for similar low-income populations[71];
(8) most states that have either co-payments or premiums and not both – unlike Colorado, which imposes both co-payments and premiums[72]; and,
(9) it may cost more in added bureaucracy to collect the premiums than the funds received.[73]

Ironically, the State cited a study in its recent application to the federal government for a $1.3 million grant to improve access to health insurance that showed families below 185 percent of poverty are virtually unable to pay additional premiums for

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[65] "Minutes. . .," December 7, 1999, p. 5; see also, "Minutes. . .," January 4, 2000, p. 3.

[66] "Minutes. . .," March 7, 2000, p. 7.

[67] "Minutes of the Children's Health Plan Policy Board Meeting," Department of Health Care Policy and Financing, April 4, 2000, p. 5.

[68] "Minutes. . .," April 4, 2000, p. 6. See also, Mary Jo O'Brien, et al, "State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions," p. 8.

[69] "Minutes. . .," April 4, 2000, p. 7.

[70] "Minutes of the Children's Health Plan Policy Board Meeting," Department of Health Care Policy and Financing, June 6, 2000, p. 4.

[71] "Minutes. . .," June 6, 2000, p. 4.

[72] "Minutes. . .," July 11, 2000, p. 5.

[73] "Minutes. . ., July 11, 2000, p. 6.

health coverage after spending money for essentials, such as food, housing and transportation.[74]

And yet, by design, the State continued to impose premiums on families with children enrolled in CHP+ at levels as low as 100 percent of poverty. Even the Owens initiative would continue to impose premiums on families with children wishing to enroll in CHP+ at levels as low as 150 percent of poverty.

In trying to come up with policy to address these important problems, CBHP Board members expressed frustration with the fact that they are "constrained by the statutory framework that created the CHP+ program."[75] This is true in a number of arenas, such as trying to overcome the problem of lengthy and complicated Medicaid and CHP+ applications while the Legislature continues to require a Medicaid assets test and other barriers to coverage.

- ***Conflicting Ideology:*** In the name of "personal responsibility" and "teaching people the value of health insurance," as the State Auditor has noted, the State has often lost sight of other fundamental goals of the program, such as providing health insurance coverage to children. Some may ask what "value is taught" to those working families who play by the rules, strive to do right be their children, and yet, face a stifling bureaucracy that thwarts health coverage to their kids.

  As the *Denver Rocky Mountain News* wrote over a year ago, ""…jumping through hoops might be a whole lot easier for some of them than filling out the required forms, which rival the renowned handiwork of the Internal Revenue Service for clarity and ease of compliance. The logic of erecting such paperwork obstacles escapes us. Government doesn't have to offer insurance to the children of the working poor, but having made the decision to do so, it's hardly fair then to smother the program beneath layers of red tape."[76]

Common Goals

The stated purpose of Title XXI of the Social Security Act or the State Children's Health Insurance Program is "to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children."[77]

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[74] Department of Health Care Policy and Financing, State of Colorado, "Health Care Coverage Cooperatives Grant Proposal," http://www.chcpf.state.co.us/HealthIns/grantpro.html.

[75] "Minutes. . .," June 6, 2000, p. 6.

[76] "Building a Paperwork Wall," *Denver Rocky Mountain News*, Editorial, June 10, 1999.

[77] "The Balanced Budget Act of 1997: Conference Report to Accompany H.R. 2015" (Report 105-217), U.S. House of Representatives, Public Law 105-33, 1997, p. 314.

As Colorado strives to improve its health programs providing health care coverage to children, the State needs to identify common goals and to aggressively address conflicting goals or implementation policies.

This includes reforming both CHP+ and Medicaid to obtain the best out of the current "public-private partnership," rather than adopting what some view as the worst aspects of what government and the private sector bring to the table. One argument for privatization, for example, is that it brings about administrative efficiencies through the private sector. However, CHP+ is currently running 27 percent administrative costs.

As for Medicaid, while it has far lower administrative costs, the current system of requiring families to apply through county welfare offices continues to promote the "welfare stigma" that many state leaders do not like about the program.

To improve CHP+ and Medicaid, there appears to be some common goals[78] that most people would seem to agree upon, including:

1) *Improving Coverage and Child Health*
2) *Removing Access Barriers to Care*
3) *Reducing Bureaucracy and Administrative Costs*
4) *Maximizing Federal Funds*
5) *Eliminating "Welfare Stigma" and Establishing "Personal Responsibility"*
6) *Improving Quality of Care*
7) *Adopting Best Practices*

As Colorado considers changes to its health care programs, any changes should be reviewed within the context of whether it achieves the common goals outlined above or those identified through a strategic planning process, as recommended by the State Auditor.[79]

- ***Improving Coverage and Child Health:*** Enrollment increases have flattened out in recent months and Colorado will return up to $19 million in unspent CHIP funds at the end of September unless Congress takes action in the near future to allow states to retain some of their unused CHIP allotments.[80]

[78] For example, see "Minutes. . .," July 11, 2000, p. 4. At that meeting of the CBHP Policy Board, the Minutes outline guiding principles that were "derived from the mission of the Children's Basic Health Plan [including]: broad access; highly effective; improved health status; significant enrollment; and education to achieve personal and fiscal responsibility."

[79] Office of the State Auditor, pp. 37-38.

[80] See, McAllister and Wehrman articles dated September 28, 2000. *NOTE: The Congress is currently considering legislation that would allow states that have unspent CHIP allotments to keep 60 percent of those funds for two additional years. As a result, Colorado would be allowed to keep $11.5 million of its unspent FY 1998 CHIP allotment if that legislation passes this legislative session.*

Regarding this fact, the *Denver Rocky Mountain News* writes, "It's too bad that money that could have benefited Colorado children is going elsewhere."[81]

> *". . .somewhere between 10 million and 11 million children in America still lack health insurance. That's way over 15 percent. The majority could be covered under either CHIP or Medicaid. . . and we will be judged – you and I and all of us – on how well we do from here on out."*
>
> -- President Bill Clinton
> Speech Before the American Academy of Pediatrics
> October 12, 1999

For CHIP to fulfill its promise, Colorado should do everything it can to cover as many children as possible.

Moreover, there is the real threat that if states do not utilize their allotted federal funds that they could disappear. For example, the U.S. Senate Labor-HHS Appropriations Committee has sought to repeal $1.9 billion in unspent CHIP funds, including the estimated $19 million in unspent funds from Colorado, and redirect those funds to other federal spending.

One analysis of the impact such a cut in CHIP funding could have notes, "The rescission would establish a dangerous precedent of using SCHIP funds to compensate for shortfalls in discretionary spending and consequently would call into question the extent to which states can rely on Congress to provide SCHIP funds as promised for future years."[82]

Letters were organized by House members[83], Senate members[84] and outside organizations in opposition to this reduction in CHIP funds.[85] Fortunately, due to the organized opposition, it appears far less likely that the rescission proposed in the Senate will be enacted by the full Congress.

- ***Removing Access Barriers to Care:*** Insurance coverage does not always lead to increased access to health care.

  According to the General Accounting Office, "Having health insurance and having a regular source of health care facilitate a family's use of health services, but some

[81] "Children's Health Insurance," *Denver Rocky Mountain News*, Editorial, July 15, 2000.

[82] Guyer, Jocelyn, "State Appropriations Committee Proposal Poses Threat to SCHIP," Center on Budget and Policy Priorities, June 2, 2000, p. 1.

[83] DeGette, Diana, and 23 other members of Congress, "Dear Colleague Letters", U.S. House of Representatives, June 22, 2000, and June 29, 2000.

[84] Bayh, Evan, and George Voinovich, "Dear Colleague Letter," U.S. Senate, June 2000.

[85] O'Bannon, Frank, and Lincoln Almond, "Letter to Congress," National Governors' Association, http://www.nga.org/Governor/SCHIP1.asp; American Academy of Pediatrics, and 38 Other National Organizations, "Letter to Congress," June 9, 2000.

families experience systemic, financial, and personal barriers to care. Systemic barriers can include a lack of primary care providers readily available in the neighborhood, physicians' missing opportunities to provide vaccinations during health care visits, and physicians' refusing to accept certain patients. Financial barriers, apart from lack of insurance, can include lack of funds to make copayments or pay for uncovered services. Personal barriers can include parents' lack of knowledge that care is needed and language differences between parents and providers."[86]

- ***Reducing Bureaucracy and Administrative Costs:*** Of the $16.2 million projected expenditures in FY 2000 for CBHP/CHP+, the State Auditor estimates that almost $6 million, or 27 percent, of that amount are for administrative costs.[87]

  Writes Carla Crowder of the *Denver Rocky Mountain News*, "The health plan is designed to bridge the gap between Medicaid, a federal entitlement, and private insurance, which shuts out many of the working poor. But Colorado lawmakers, experimenting with a public-private partnership, designed a cumbersome, wasteful program."[88]

  The State Auditor adds, "The Department needs to continue to explore options for reducing administrative costs."[89]

  To the greatest extent possible, it would be far better to spend limited funding for health services rather than administration and bureaucracy.

- ***Maximizing Federal Funds:*** Colorado ranks 48th in the nation in federal aid per capita to state and local governments.[90] Part of this is due to the fact, as HCPF points out, "Colorado has the lowest participation of all states in the Medicaid program; only 5.9% of the state's non-elderly population are in the Medicaid program, less than half of the national average of 12.2%."[91]

  Other policies also limit the draw of federal funding, such as the CHP+ premium structure (even that proposed by Governor Owens). In fact, the current premium

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[86] General Accounting Office, *Health Insurance Coverage Leads to Increased Health Care Access for Children*, p. 23.

[87] Office of the State Auditor, p. 24.

[88] Crowder, Carla, "State Health Plan for Poor Blasted," August 1, 2000.

[89] Office of the State Auditor, p. 3.

[90] U.S. Census Bureau, U.S. Department of Commerce, *Federal Aid to States for Fiscal Year 1999,* April 2000, p. xiii.

[91] Department of Health Care Policy and Financing, "Health Care Coverage Cooperatives Grant Proposal," p. 3.

collection system is being paid with virtually state-only dollars because the State is exceeding the 10 percent federal cap in administrative expenses for CHP+.

Furthermore, as the State Auditor notes, "Premium revenues. . .are deducted from benefit costs, thereby decreasing the amount of costs against which the administrative limit is calculated. This means premium revenues have the effect of decreasing the amount of dollars allowable for administration for which federal matching funds can be obtained."[92]

With the Taxpayers' Bill of Rights Amendments (TABOR) limits, the State needs to be creative and innovative in ways to overcome the challenges posed by those limits, which includes maximizing federal dollars (or improving our "fair share" of federal funding).

- ***Eliminating "Welfare Stigma" and Instilling "Personal Responsibility":*** Out of the desire to: (1) instill "personal responsibility" and the "value of private health insurance" on families; and, (2) eliminate the "welfare stigma" of public programs – a number of proposed solutions have arisen.

  The operating model for CHP+ currently includes: (1) ensuring CHP+ is not an "entitlement" program; (2) imposing premiums and co-payments on families for their children's health; (3) the adoption of a "commercial model for CHP+; and, (4) the desire to have CHP+ to work as a "public-private partnership" through the use of private contractors.

  For example, according to the State Auditor, "The legislative intent is that requiring financial participation will help families learn to value the services received and be more prepared for the cost-sharing requirements of private insurance."[93]

  The State Auditor adds, "The term 'commercial model does not appear in CBHP statutes. However, the Department and the Board report they have received clear indications from the General Assembly since the early days of the program that this is the type of model the program should emulate."[94]

  And finally, as Governor Bill Owens says, "While there may need to be improvements made to the CBHP, I continue to support an insurance model rather than an entitlement model. The former fosters a sense of personal responsibility and enables low-income Coloradans to be served not as clients of a welfare-state

[92] Office of the State Auditor, p. 43.

[93] Office of the State Auditor, p. 16.

[94] Office of the State Auditor, p. 36.

entitlement program but rather to be treated like middle-class Coloradans – as health insurance consumers."[95]

However, an important question that should be raised is whether the current operating models for CHP+ truly address the goals of the program, including the desire to instill "personal responsibility" and eliminate "welfare stigma."

For example, with respect to the imposition of premiums in CHP+, a report by Health Management Association and the Lewin Group notes, " While the goal is to set up insurance systems that closely resemble private insurance, higher-income families typically do not face monthly premium bills of coverage nor need to track their own cost-sharing obligations."[96]

Governor Owens has recognized this problem and his proposal to eliminate the monthly premium reflects this understanding. However, other barriers such as the complicated and burdensome application process remain and should be addressed.

And finally, the State could adopt changes to the Medicaid program to eliminate any "stigma" associated with it. For example, eligibility determination must currently be made in country welfare offices and applicants have expressed negative experiences with county eligibility workers who often continue to operate under a welfare model.[97] As the Kaiser Commission on Medicaid and the Uninsured states, ". . .it is critical to change the perception of Medicaid from a welfare program to a stand-alone, health insurance for low-income families."[98]

The continued imposition of a Medicaid assets test by the State is also a holdover from the old, out-dated welfare model.

- ***Improving Quality of Care:*** Children are not "little adults." As the final report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry notes:

  "Children have health and developmental needs that are markedly different from adults and require age-appropriate care. Developmental changes, dependency

[95] Owens, Bill, Governor of Colorado, "Letter to State Officials Nancy McCallin, Rick O'Donnell and Jim Rizzuto," July 28, 2000.

[96] O'Brien, Mary Jo, et al, "State Experiences With Cost-Sharing Mechanisms in Children's Health Insurance Expansions" p. 33.

[97] O'Brien, Mary Jo, et al, "State Experiences With Access Issues Under Children's Health Insurance Expansions," p. 30.

[98] Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Children: Overcoming Barriers to Enrollment: Findings From a National Survey*, January 2000, p. 33.

on others, and different patterns of illness and injury require that attention be paid to the unique needs of children in the health system."[99]

This requires consideration and procedures that are pediatric-focused by the health care system.[100] In an article printed in the publication *The Future of Children*, Elizabeth Jameson and Elizabeth Wehr write:

"Because of children's ongoing development, illness can affect them with greater consequence than adults. Inadequately treated, childhood illness can preclude for an individual's life the possibility of normal functions or adequate adjustment to a chronic or disabling condition. Thus, children have a strong claim to access to specialized providers (that is, children's hospitals, clinics, and practitioners) who have the training and experience to recognize, diagnose, and manage the physical, developmental, and emotional conditions characteristic of childhood disorders."[101]

- ***Adopting Best Practices:*** A growing number of reports are beginning to compare state-operated Medicaid and CHIP plans.

  These reports are by the states themselves, the federal government, advocacy groups at the state and national levels, the media, and non-profit research or philanthropic groups.[102]

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[99] President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Quality First: Better Health Care for All Americans*," March 1998, p. 131.

[100] See, for example, Institute of Medicine – National Research Council, *Paying Attention to Children in a Changing Health Care System*, National Academy Press, 1996.

[101] Jameson, Elizabeth, and Elizabeth Wehr, "Beyond Benefits: The Importance of a Pediatric Standard in Private Insurance Contracts to Ensuring Health Care Access for Children," *The Future of Children*, Winter 1994, Vol. 4, No. 3, pp. 119-120.

[102] See for examples, National Conference of State Legislatures, "Title XXI Turns Three: States Make Progress in Covering Uninsured Kids," *State Health Notes*, July 31, 2000; American Public Health Services Association (APHSA*), CHIP Outreach and Enrollment: A View from the States,* September 1999; U.S. Department of Health and Human Services, "The State Children's Health Insurance Program: HHS Fact Sheet," February 24, 2000; Children's Defense Fund, *All Over the Map: A Progress Report on the State Children's Health Insurance Program (CHIP),* July 2000; Mary Jo O'Brien, et al, "State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions," May 2000; Mary Jo O'Brien, et al, "State Experiences with Access Issues Under Children's Health Insurance Program," May 2000; Congressional Research Service, May 1, 2000; Cindy Mann, et al, "Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children," February 1, 2000; Donna Cohen Ross, "Sources of Federal Funding for Children's Health Insurance Outreach," Center on Budget and Policy Priorities, February 17, 2000; General Accounting Office, April 2000; The Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Children -- Overcoming Barriers to Enrollment: Findings From a National Survey*, January 2000; The Kaiser Commission on Medicaid and the Uninsured, *Express Lane Eligibility: How to Enroll Large Groups of Eligible Children in Medicaid and CHIP*, December 1999; National Health Policy Forum, "Reinventing Medicaid: Hoosier Healthwise and Children's Health Insurance in Indiana," Site Visit Report, April 17-19, 2000; Robert Pear, "40 States

Colorado should aggressively seek out those best practices from other states and integrate them into our Medicaid and CHP+ plans.

Recommendations

I. COVERAGE AND OUTREACH

1. ***Expand Coverage for CHP+ to 200 Percent of Poverty:*** According to the Children's Defense Fund, "Income eligibility for 19 CHIP programs is set at 200% of the Federal Poverty Level (FPL), and another 10 states have set eligibility above 200% as of January 2000."[103] For example, New Mexico has expanded CHIP eligibility up to 235 percent of poverty.

   The CBHP Legislature Committee has begun developing a legislative list for next year that includes an expansion of CHP+ in Colorado up to 200 percent of poverty.[104]

2. ***Change Age-Based Eligibility Rules:*** Children in the same family are sometimes eligible for both Medicaid and CHP+ due to different income standards for different age groups. Other states have adopted more uniform eligibility standards (e.g., cover all low-income children below 133 percent of poverty in Medicaid and children between 133 and 200 percent of poverty in CHP+).

   The Center on Budget and Policy Priorities found that as "of July 1999, 34 states and the District of Columbia had eliminated or limited age-based eligibility standards in Medicaid."[105] Colorado and 15 other states maintain over two standards based on children's age.[106]

Forfeit Health Care Funds for Poor Children," *New York Times*, September 24, 2000; Jennifer Steinhauer, "States Prove Unpredictable in Aiding Uninsured Children," *New York Times,* September 28, 2000.

[103] Children's Defense Fund, p. 21.

[104] "Minutes. . .," April 4, 2000, p. 2.

[105] Mann, Cindy, Donna Cohen Ross and Laura Cox**,** "Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children," Center on Budget and Policy Priorities, February 1, 2000, http://www.cbpp.org/ 2-1-00health.htm, p. 15.

[106] Colorado's Baby Care/Kid Care Medicaid covers children from 0-5 years of age up to 133 percent of poverty. The regular Medicaid program covers children from 6-16 years of age up to 100 percent of poverty. Adolescents who are 17 and 18 years of age are covered up to 38 percent of poverty, although that will change due to federal law ("Waxman kids") which requires those children to be covered up to 100 percent of poverty by 2002. CHP+ and CICP provide an overlay of coverage up to 185 percent of poverty for children up to age 19. See, for example, Table 12 in Office of the State Auditor, p. 87.

In a national survey, six in ten parents with children either enrolled in Medicaid or uninsured did not know that eligibility levels varied by age and income levels.[107] Families are often confused when one child is eligible for coverage while another is not or eligible for a different program, or when a child loses coverage after a birthday.

A report by Health Management Associates and the Lewin Group adds, "Determining eligibility can still be complicated in cases where all children in a family are not covered by one program. Such families have to follow different enrollment procedures and redetermination schedules for each program child. Once children are enrolled, families must learn about different benefit packages and provider networks for each program."[108]

Colorado should move toward the adoption of a single age-based eligibility standard. For example, New York is preparing to raise the Medicaid income eligibility standard for children up to 133 percent of poverty over age 1. They would still get an enhanced CHIP matching rate for these children but feel it is important to provide a single eligibility standard for families, as best as possible.[109]

3. ***Adopt the 12-Month Continuous Eligibility in Medicaid, As Is Provided for in CHP+:*** According to Medicaid Director Timothy Westmoreland, ". . .under Section 1902(e)(12) of the Social Security Act, States may grant continuous eligibility to children under age nineteen for up to twelve months, even if there is a change in family income, assets, or composition. States may also grant continuous eligibility under SCHIP."[110]

   As of December 1999, 14 states had adopted 12-month continuous eligibility in both Medicaid and CHIP, nine states had adopted continuous eligibility only in their CHIP plan (including Colorado), and Florida had adopted 12-month continuous eligibility only for younger children in its Medicaid program.[111]

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[107] Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Children – Overcoming Barriers to Enrollment: Findings From a National Survey*, p. 7.

[108] O'Brien, Mary Jo, et al, "State Experiences With Access Issues Under Children's Health Insurance Expansions," p. 17.

[109] Mann, Cindy, et al, "Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children," p. 15.

[110] Westmoreland, Timothy, "Letter to State Health Officials," Health Care Financing Administration, June 26, 2000. *NOTE: This letter was a solicitation to states for a new grant program, "Medicaid/SCHIP Eligibility Pilots." This grant program is "designed to identify and test innovative ways to increase enrollment in Medicaid and SCHIP by simplifying the eligibility and enrollment process."*

[111] Kaiser Commission on Medicaid and the Uninsured, "Selected Simplification Criteria: Medicaid for Children and CHIP-funded Separate State Programs (SSP)," December 1, 1999.

As one advocacy group notes, "Continuous eligibility not only reduces administrative burdens, but it improves the likelihood of including CHIP and Medicaid enrollees in assessments of access and quality. Health plans typically require members to be enrolled for at least 12 months in order to be included in quality assessment reports."[112]

In addition to problems with quality assessments, health plans also have poor incentives to provide certain health services to enrollees that are likely to leave the health plan in the near term. As the Alpha Center has found, "an estimated 40 percent go on or off Medicaid during the course of a year, and this figure does not take into account those who switch among health plans."[113] This certainly weakens any incentive for managed care plans to provide certain prevention, health and non-medical services that offer only longer-term benefits.

Colorado should provide 12-month continuous eligibility for all of its children and not specifically exclude it for its lowest-income children covered by Medicaid. If nothing else, Colorado should recognize the importance of continuity of care during the earliest years of life and adopt Florida's policy of providing continuous eligibility in Medicaid through age 5.

4. ***Adopt Presumptive Eligibility in Medicaid and CHP+, As Is Granted to Pregnant Women in Medicaid:*** The Medicaid program, as a result of a DeGette Amendment to the Balanced Budget Act of 1997[114], allows states to give certain entities the ability to determine, based upon preliminary information, whether the family income of a child meets the State's Medicaid income eligibility limits. If it is, the child can be provided temporary or "presumptive eligibility" for Medicaid and has until the end of the following month to submit a full Medicaid application, or the presumptive eligibility application can serve as the full Medicaid application.

   In a comprehensive national survey by the Kaiser Commission on Medicaid and the Uninsured to better understand barriers to coverage and to test the usefulness of ideas to facilitate enrollment, 56 percent of families that had eligible

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[112] Children's Defense Fund, p. 67.

[113] Lipson, Debra, and Amy Bernstein, "Doing the Right Thing: The Role of Market Forces and Public Policy in Managed Care Organizations' Performance on Child Health," *Health Care for Children: What's Right, What's Wrong, What's Next* (ed. Ruth E.K. Stein), United Hospital Fund, 1997, pp. 247-248.

[114] This amendment, which added language to Section 1920 of the Social Security Act, was successfully offered by Rep. Diana DeGette at a House Commerce Committee mark-up of the Balanced Budget Act in 1997.

uninsured children said that it would make them much more likely to enroll if they could immediately enroll and provide all the forms later.[115]

Other states, including Nebraska, have adopted presumptive eligibility in their Medicaid and CHIP plans.[116]

Colorado has already adopted presumptive eligibility for pregnant women in Medicaid's Baby Care/Kid Care Program (Sec. 26-4-508, C.R.S.) and should do so for children in both Medicaid and CHP+. This is very similar to the pre-enrollment period already adopted by CHP+.

5. ***Improve Outreach Efforts, Including Spending the $5 Million in TANF Outreach Dollars on Medicaid and CHP+:*** The State has engaged in important work with satellite eligibility determination sites (SED), the establishment of the *Colorado Covering Kids Initiative* through a grant, and contracting with outside consultants to improve and evaluate outreach and marketing efforts of CHP+.[117]

   However, there has been a lack of spending of $5.2 million available to states for health care outreach and enrollment in Medicaid and CHP+. As of December 1999, Colorado had spent only 7 percent of its $5.2 million allotment for outreach and enrollment. Some state officials have argued the money was only available for Medicaid outreach.[118] This is inaccurate.

   As the Department of Health and Human Services writes, "States can. . .use their allocations of the $500 million Federal fund available under section 1931 of the Social Security Act, in accordance with guidance issued in the January 6, 2000 letter to State officials and the May 14, 1997 *Federal Register* notice, or State Maintenance of Effort funds for outreach and training activities for Medicaid and SCHIP."[119]

   States can also use Medicaid, TANF and MOE funding to improve outreach and enrollment in CHP. In addition, there are a number of additional federal grants,

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[115] Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Children – Overcoming Barriers to Enrollment: Findings From a National Survey*, p. 16.

[116] Children's Defense Fund, p. 21.

[117] See, for example, Department of Health Care Policy and Financing, "Framework for State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act," pp. 60-64, 88; Office of the State Auditor, pp. 55-57; "Minutes. . .," December 1999, pp. 2-3.

[118] Even it this were true, Colorado should have spent these funds more rapidly, particularly in light of the fact that numbers of Medicaid recipients were wrongly dropped from coverage as those families left the welfare rolls.

[119] U.S. Department of Health and Human Services, *Report to the President on School-Based Outreach for Children's Health Insurance*, July 2000, p. 13.

such as the Maternal and Child Health program, Healthy Child Care America, Rural Health Outreach Grant Program, and Primary Care Associations (PCA) funds, that can be used to improve outreach and enrollment of children in Medicaid and CHP+.[120]

Rather than returning $19 million in unspent federal funding, Colorado should be as creative as possible in exploring additional ways to expand outreach and enrollment efforts. As noted above, resources to achieve this goal can be obtained from a number of non-state sources, including the federal government and private sources (as the State is currently benefiting from with its *Covering Kids* grant).

6. ***Do Not Eliminate CICP for Children:*** There has been some discussions within the State about eliminating CICP for children because of concern that some families do not enroll in CHP+ because CICP remains as a safety net options for children. However, the problem is not CICP. The problem is CHP+.

   CICP is an important reimbursement program for State's safety net providers that serve the uninsured. In fact, it is a model program that other states are seeking to emulate. Instead, the focus should be to make the CHP+ plan more attractive and available to families.

   Moreover, the State should be extremely careful in moving forward with the idea of eliminating CICP for children. If that were to happen, the State would, in effect, be providing benefits to adults but not for children. As a result, the only option for children would be to pay premiums, pay copayments, fill out significant paperwork and be forced into a HMO whether they want one or not in order to receive health care coverage.

   In addition, certain ineligible children for CHP+, such as certain immigrant children, need CICP as a fallback until legislation is enacted at both the federal and state levels to grant those children coverage.[121]

II. ENROLLMENT BARRIERS

1. ***Inform Families About Change in CHP+ Premium Structure:*** Families received previous notices that they had to pay premiums or be turned over to collections. They and those that found monthly premiums to be a barrier to begin or maintain coverage need to immediately be informed that the CHP+ premium structure has been changed.

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[120] Ross, Donna Cohen, "Sources of Federal Funding for Children's Health Insurance Outreach" (entire report).

[121] As was reported by Jessica Wehrman in the *Denver Rocky Mountain News* on September 28, 2000, "Three other DeGette measures were passed by the House Commerce Committee on [September 26]. Those measures would expand the Children's Health Insurance Program [and Medicaid] to legal immigrant children and pregnant women. . . ."

The State should also closely monitor whether the proposed annual premium structure makes sense. It should be noted that Montana, like a number of other states, has moved to eliminate their $15 application fee in order to facilitate enrollment in its CHIP plan.[122] As a result, the annual premium may very well prove to be a barrier to coverage that is unworthy of the effort.

2. ***Eliminate the Medicaid Assets Test:*** Colorado is one of just a few states in the nation that continues to place this stigma and complicated enrollment barrier for low-income children. In sharp contrast, Colorado does not impose resource standards or an assets test on pregnant women for coverage in Medicaid's Baby Care/Kid Care Program (Sec. 26-4-508, C.R.S.).

   In addition to the fact that the assets test complicates the application form for coverage, for those that are on Medicaid, the assets test makes it terribly difficult for families to move out of poverty. In Alysia Boyd's case, for example, she works and attends school in order to do right by her children. She was able to save enough money to get a car because catching light rail and a bus to get to child care for her daughter Mariah, who has asthma, was getting sick and finding herself in the hospital every other month.

   However, in getting the car, Alysia Boyd found that she had traded in her daughter's health coverage through Medicaid due to the assets test.[123]

   Moreover, due to the assets test on children, children at similar poverty-levels are covered differently by Medicaid or CHP+. In fact, 32 percent of all CHP+ covered children have incomes below 100 percent of poverty.

3. ***Create a Single Definition of "Family Income":*** Medicaid and CHP+ have different definitions of "family income," which complicates the enrollment form and eligibility.

   In fact, there appears to be a conflicting requirement for income within CBHP/CHP+ itself. According to the State Auditor, "The eligibility rule for CBHP states that income has to be verified for income earned 'within 30 days of the date of application.' However, in the section regarding the calculation of gross family income for determining eligibility, the rule states that all income received by the family 'in the calendar month prior to the date of application' shall be counted. These two time periods may not be the same."[124]

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[122] "Report Criticizes State Children's Insurance Programs," Associated Press State and Local Wire, May 25, 2000.

[123] Kreck, "Barriers Against Children's Health: Many Kids in Poverty Drop Through Holes in State's Poorly Funded Medical Program," February 16, 2000.

[124] Office of the State Auditor, p. 58.

As the State Auditor recommends, "The CBHP Policy Board should revise the CBHP eligibility rule to. . .require verification of income for the same time period used to calculate gross family income for the purpose of eligibility determination."[125]

The State should also create a single definition of "family income" for both Medicaid and CHP+.

4. ***Simplify the Medicaid and CHP+ Application and Enrollment Processes:*** First and foremost, the State should adopt a simplfied enrollment application, as have been adopted by a number of other states.

   According to the Kaiser Commission on Medicaid and the Uninsured, 67 percent of parents of eligible uninsured children have tried to enroll their children in Medicaid in the past. Of those that were unable to complete the application process, parents cited difficulty of getting all the required papers (72%), overall hassle of the enrollment process (66%) and belief that the process was complicated and confusing (62%) are reasons for not applying for coverage.[126]

   The Federal model Medicaid/CHIP application is two pages. According to the Center on Budget and Policy Priorities, "As of November 1998, 41 states had adopted Medicaid applications or joint SCHIP/Medicaid applications that were five pages or less. Many states have two- or three-page joint applications."[127]

   The Colorado enrollment application is extremely complicated and stands in sharp contrast to those adopted by other states. Such barriers to coverage are real and should be addressed by the State.

5. ***Simplify Redetermination Procedures in Medicaid and CHP+:*** As the Center on Budget and Policy Priorities points out, "Relatively small changes in family income and expenses, as well as changes in family composition (such as birth, divorce, separation, or marriage), easily can result in a child becoming ineligible for one program and eligible for the other. A seamless and well-coordinated redetermination process would assure that children who are no longer eligible for the program in which they have been enrolled are evaluated for the other

[125] Office of the State Auditor (see Recommendation No. 7), p. 59.

[126] Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Children – Overcoming Barriers to Enrollment: Findings From a National Survey*, pp. 9-10.

[127] Mann, Cindy, et al, "Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children," p. 13.

program and, if eligible, are enrolled without a new application and without any lapse in coverage."[128]

In sharp contrast, the State Auditor says that in Colorado, "Families disenrolled from Medicaid programs may not always be referred to or receive information about CBHP. . .If the family submits the redetermination form and is found ineligible for Medicaid, the county does not forward information to CBHP, because the redetermination form is not designed so that it can be used as a referral form to CBHP."[129]

Concludes the Kaiser Commission on Medicaid and the Uninsured, "Unwarrented disenrollment disrupts continuity of care, decreases access to care, and dilutes state efforts in increasing enrollment by contributing to the constant 'churn' of children cycling on and off Medicaid and CHIP. . .States should apply the same tools used to streamline the initial enrollment process to make the redetermination process more accessible."[130]

6. ***Reduce the Waiting Time That It Takes to Get Children Covered:*** The Office of the State Auditor has found that it can take months for families to receive a disposition on whether their children can be covered by either Medicaid or CHP+.

   The State could undertake a number of initiatives to address this problem, including: (1) placing Medicaid eligibility technicians at CHA; (2) placing additional Medicaid eligibility technicians at additional locations, such as community health centers, hospitals, pediatric clinics, etc.; and/or, (3) initiating some improved accountability between HCPF, Medicaid and CHA on getting children enrolled in a timely manner (see Recommendation IV.3 below).

7. ***Reduce or Eliminate Verification and Documentation Requirements:*** As the Kaiser Commission found in a nationwide survey, two-thirds of people found the enrollment process for Medicaid was either too difficult or complicated and confusing. In Colorado, this includes having to report everything from income to interest earned on a savings account.

   As the Center on Budget and Policy Priorities notes, "Under Federal Medicaid law, the only verification that families must submit is proof of the child's immigration status, a requirement applicable only to noncitizens. In Medicaid, as

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[128] Mann, Cindy, et al, "Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children," p. 19.

[129] Office of the State Auditor, p. 96.

[130] Kaiser Commission on Medicaid and the Uninsured, "Enrolling Uninsured Children in Medicaid and CHIP," Fact Sheet, January 2000.

in SCHIP, states can rely on the applicant's statements to establish any other eligibility factor, including income, resources, identity, age, and residency."[131]

The State should undertake efforts to reduce or eliminate as many verification and documentation requirements as possible.

III. HEALTH BENEFITS

1. ***Add a Dental Benefit to CHP+:*** As the State Auditor notes, "Under Senate Bill 00-71, $10 million will be deposited into the Children's Basic Health Plan Trust from the State's share of federal tobacco settlement monies beginning in Fiscal Year 2001. The Act authorizes the CBHP Policy Board to add dental service to the schedule of benefits for CBHP, provided the Board determines that there are an adequate number of dentists to serve the children in CBHP and that there are sufficient resources to fund the services."[132]

   As the State Legislature has allowed, the State should move as rapidly as possible to adopt a dental benefit. In light of the problems caused to children lacking dental care and that Colorado is the last state in the nation to adopt a dental benefit, it is important that the State move forward as quickly as possible.

2. ***Improve Benefits for Other Services in CHP+:*** With respect to other benefits in CHP+, such as prescription drugs, vision, mental health, and hearing, Colorado has imposed service limits on all four of these important benefits.[133] To ensure that children with special health care needs receive the care they need, the State has adopted special procedures to identify children with special health care needs to provide assistance to ensure that the children receive much needed services in conjunction with the State's Title V program, the Health Care Program for Children with Special Needs (HCP), the State's Medicaid Safety Net Project, and the Children's Comprehensive Care (CCC) Project.[134]

   It might be more efficient and less complicated to, as best as possible, provide for the comprehensive needs of children through one health care system rather than requiring families to access a number of different state programs or resources for children with special health care needs.

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[131] Mann, Cindy, et al, "Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children," p. 16. In addition, see Sally Richardson, "Letter to State Health Officials," Health Care Financing Administration, U.S. Department of Health and Human Services, September 10, 1998.

[132] Office of the State Auditor, p. 15.

[133] General Accounting Office*, Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits*, pp. 24-26.

[134] Department of Health Care Policy and Financing, "Framework for State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act," pp. 45-46, 87-88.

IV. PROGRAM EFFICIENCY AND COORDINATION

1. ***Improve Coordination Between All Children's Health Programs:*** As the State Auditor points out, "Improving communication and coordination between eligibility and enrollment systems can lessen administrative duplication, decrease excessive application lag times, avoid simultaneous enrollment in both programs, and minimize confusion for families."[135]

2. ***Reduce Administrative Costs:*** The State Auditor writes, "It is critical to the success of CBHP that the CBHP Policy Board and the Department address these two fundamental issues: identifying ways to decrease the duplicate oversight and administrative layers of the Children's Basic Health Plan and reducing administrative costs. If the overall goal is to maximize the use of available funds to provide health care to uninsured, low-income children, such efforts will enable the program to have a clearer direction, create more specific lines of authority and responsibility, and result in more dollars going to health care as opposed to administrative functions."[136]

   For example, among a host of recommendations to address administrative costs, the State Auditor adds, "Another option not discussed by the Department in its budget request would be to develop a stand-alone program using the Medicaid administrative structure to the greatest degree possible. . . Oregon reported that by operating its CHIP program entirely out of the state Medicaid office, it was able to hold administrative costs to 2.9 percent of health care costs. The Oregon program may offer some ideas for using the existing Medicaid infrastructure without creating an entitlement program."[137]

3. ***Move Medicaid Eligibility Determination Out Into the Communities:*** As the State Auditor notes, "Medicaid eligibility must be *determined* by the county department of social services in which the applicant resides (Sec. 26-4-106(1), C.R.S.). This means only the counties can actually enroll individuals in the Medicaid program."[138]

   Unfortunately, as one report notes, "In Colorado, where applicants must come to county welfare offices to complete applications, enrollees report unfavorable experiences with eligibility workers."[139]

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[135] Office of the State Auditor, pp. 91-92.

[136] Office of the State Auditor, p. 28.

[137] Office of the State Auditor, p. 27.

[138] Office of the State Auditor, p. 92.

[139] O'Brien, Mary Jo, et al, "State Experiences With Access Issues Under Children's Health Insurance Expansions," p. 30.

As a result, the requirement for Medicaid eligibility to be determined in county welfare offices maintains the very "welfare stigma" that the State expresses its desire to eliminate. Such determinations could be further moved out into the communities across the State, such as in community health centers, hospitals, etc. Such a move could reduce the "welfare stigma" associated with Medicaid applications being approved only through county welfare offices.

The State should also adopt a recommendation by the State Auditor to house Medicaid eligibility workers at CHA. The recommendation reads, "This is the most straightforward solution from the viewpoint of processing these potentially Medicaid-eligible children in the quickest manner. This would require a change in the state law requiring county departments of social services to determine Medicaid eligibility."[140]

4. ***Maximize Federal Funding and Improve Federal-State Relations:*** It should be a common goal of State leadership and the Colorado congressional delegation to work together to improve federal-state relations. For example, our office was pleased to work with the State on the passage of two health care amendments that the State requested during the past year.[141] Furthermore, the entire congressional delegation successfully works together for funding for the University of Colorado Health Sciences Center and its Fitzsimons Campus.[142]

   In addition, the State identified a problem and recommended that Congress "fix the National School Lunch Program confidentiality issues at the Federal level to give Title XXI programs more leverage."[143] This was done with the passage of the "Agricultural Risk Protection Act" in June 2000. This bill allows school districts as of October 1, 2000, to share information about children eligible for free- or reduced-school lunch programs with Medicaid and CHIP plans.[144]

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[140] Office of the State Auditor, p. 93.

[141] This included the passage of a technical amendment from H.R. 3269 (DeGette) to the Balanced Budget Refinement Act (BBRA) that clarified states would continue to be eligible for a 75 percent federal matching rate in Medicaid for contracting with certain external quality review organizations, as the state desired. In addition, our office worked with the Colorado Department of Public Health and Environment on an amendment to the Ryan White CARE Act to protect the State's federal grant. See, "DeGette Adds Amendment to Stabilize AIDS Funding," *Denver Post*, July 21, 2000.

[142] Shore, James, "Fitzsimons – An Economic Powerhouse," *Denver Rocky Mountain News*, February 11, 2000.

[143] Department of Health Care Policy and Financing, "Framework for State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act," p. 91.

[144] "Agricultural Risk Protection Act" (H.R. 2559), U.S. House of Representatives, 106th Congress, Public Law No: 106-224. In addition, see the U.S. Department of Health and Human Services, "Report to the President on School-Based Outreach for Children's Health Insurance," p. 16.

And yet, so much more could be done if federal-state relations were to improve. For example, I supported language in the Commerce Committee mark-up on September 26, 2000, which ensures that costs incurred during the State's pre-enrollment period for children are not included under the 10 percent administrative cap after hearing from one state official that this was a concern. Unfortunately, there is rarely such communication from the State to the Congressional delegation.

For instance, The State of Colorado is scheduled to lose an estimated $25.8 million over a five-year period as a result of changes to the Medicaid disproportionate share hospital (DSH) program.[145] Legislation has been introduced and included in the Commerce Committee's mark-up on September 26, 2000,[146] that would prevent these cuts from taking place. For Colorado, this legislation would protect the State's Medicaid DSH program and CICP funding. Despite strong support from Denver Health, University Hospital, and the Colorado Health and Hospital Association to protect $26 million in federal funding to the State, there has been no communication from the State to the Colorado congressional delegation about this legislative initiative despite repeated requests for input.

V. QUALITY AND ACCESS TO CARE

1. ***Improve Cultural Competency:*** Colorado should take additional steps to recognize diversity and improve cultural sensitivity in all systems that serve children. As Health Management Associates and the Lewin Group have found in an independent review of Colorado's health programs, "In Colorado, respondents reported that many potential enrollees, particularly Hispanics, find that materials and marketing messages are unclear. Translations from English to Spanish are reportedly done in a strictly literal, word-for-word fashion, rendering many of them inadequate."[147]

   The Children's Defense Fund adds, "Racial and ethnic minorities make up less than 10% of the health care workforce, so mainstream providers need to be more

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[145] "The Balanced Budget Act of 1997," Report 105-217, pp. 272-275.

[146] See for example, Diana DeGette, U.S. House of Representatives, "The Medicaid Safety Net Hospital Preservation Act of 2000" (H.R. 3710), 106th Congress, February 29, 2000.

[147] O'Brien, Mary Jo, and Meghan Archdeacon, et al, "State Experiences With Access Issues Under Children's Health Insurance Expansions," May 2000.

According to an article by Carla Crowder of the Denver Rocky Mountain News entitled "Health Plan Recruits Children: Complicated Rules, High Premiums Place Barricades Before Poor": ". . .Spanish-language versions of one of the CHIP rules translated premium as 'prima,' which means female cousin to most Spanish speakers. Clients were warned that if they failed to pay their cousin, they could lose coverage."

culturally aware by incorporating translation services, using multilingual print materials, and recognizing cultural traditions when providing health services for ethnically and culturally diverse consumers. . .Much more needs to be done to make administrative and health care systems culturally competent and family-friendly, particularly in states with large numbers of immigrant families, so that these parents will take the step of enrolling their eligible children and accessing care."[148]

2. ***Recruit and Adequately Reimburse Providers to Improve Access to Care for Children:*** Children in Medicaid often do not have access to dental health benefits due to low reimbursement rates paid by the State. This is also a concern about adding a dental benefit to CHP+. The State must ensure adequate payments to providers to ensure adequate access to care.

3. ***Adopt Child-Specific Protections and Quality Standards:*** According to an analysis of managed care for children, "Managed care can be problematic for children with special health care needs if health plans and networks do not include an adequate number of specialists and subspecialists. Also, plans may not provide adequately for care management, medical equipment, and other needs of chronically ill children and those with disabilities."[149]

   Adds a study published by the Commonwealth Fund, "Many health care plans do not have adequate specialty provider networks that serve children. As a result, children with special needs often have to see unaffiliated providers in order to receive the care they need. This can place an additional burden on families, who must navigate complex referral processes."[150]

   As a purchaser of health care for a high-percentage of our State's children through Medicaid, CHP+ and CICP, the State has the opportunity to make profound improvements in the quality of and access to care for our children. According to United Health Plan executives Sheila Leatherman and Douglas McCarthy, "As government finances a growing share of total health care spending, its contractual role as purchaser may be its more effective means of holding plans accountable for meeting the needs of children."[151]

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[148] Children's Defense Fund, p. 69. See, in addition, Jacqueline Patterson, "Conducting Children's Health Insurance Outreach in African American Communities," Center on Budget and Policy Priorities, June 26, 2000.

[149] Children's Defense Fund, p. 49.

[150] O'Brien, Mary Jo, et al, "State Experiences With Access Issues Under Children's Health Insurance Expansions," p. 35.

[151] Leatherman, Sheila, and Douglas McCarthy, "Opportunities and Challenges for Promoting Children's Health in Managed Care Organizations," *Health Care for Children: What's Right, What's Wrong, What's Next* (ed. Ruth E.K. Stein), United Hospital Fund, 1997, p. 220.

Fortunately, the State is working to identify children with special health care needs to provide assistance to ensure that the children receive much needed services.[152] Colorado should ensure that children, particularly those with special health care needs, are receiving appropriate pediatric health care and services.

Conclusions

Colorado should not accept its "middle-of-the-pack" status among the states in terms of enrolling uninsured children in either Medicaid or CHP+. In fact, in some cases, Colorado has established itself as a particularly stingy state toward its children. For example, it imposes one of the highest premiums for its CHIP plan in the country, is the only state in the nation not to provide a dental benefit in its CHIP plan, and is just one of six states to continue to impose an assets test, which restricts coverage and access to care in its Medicaid program.

According to a *Denver Post* editorial, "The state's willingness to keep poor kids uninsured, unimmunized and unhealthy is a travesty. . .Until they do, Colorado will remain notorious for its unwillingness to help poor children."[153]

Instead, Colorado should move quickly to adopt a number of changes to its child health programs that address important goals, such as: (1) improving coverage and child health; (2) removing access barriers to care: (3) reducing bureaucracy and administrative costs; (4) maximizing federal funds; (5) eliminating "welfare stigma" and establish "personal responsibility"; (6) improving quality of care; and, (7) adopting best practices.

Policies adopted by either Medicaid or CHP+ should adhere to such *goals (see Chart below entitled "Common Goals and Recommendations for Improving the Health of Colorado's Kids").*

Recommendations that many have made that the State should strongly consider for the improvement of Medicaid and CHP+, include:

I. COVERAGE AND OUTREACH
   1. *Expand Coverage for CHP+ to 200 Percent of Poverty*
   2. *Change Age-Based Eligibility Rules*
   3. *Adopt 12-Month Continuous Eligibility in Medicaid, As Is Provided for in CHP+*
   4. *Adopt Presumptive Eligibility in Medicaid and CHP+, As Is Granted to Pregnant Women in Medicaid*

[152] Department of Health Care Policy and Financing, "Framework for State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act," pp. 45-46, 87-88; O'Brien, Mary Jo, et al, "State Experiences With Access Issues Under Children's Health Insurance Expansions," pp. 35-36.

[153] "Kids' Health Betrayed," July 3, 2000.

5. *Improve Outreach Efforts, Including Spending the $5 Million in TANF Outreach Dollars on Medicaid and CHP+*
6. *Do Not Eliminate CICP for Children*

II. ENROLLMENT BARRIERS
1. *Inform Families About Change in CHP+ Premium Structure*
2. *Eliminate the Medicaid Assets Test*
3. *Create a Single Definition of "Family Income"*
4. *Simplify the Medicaid and CHP+ Application and Enrollment Processes*
5. *Simplify Redetermination Procedures in Medicaid and CHP+*
6. *Reduce the Waiting Time That It Takes to Get Children Covered*
7. *Reduce or Eliminate Verification and Documentation Requirements*

III. HEALTH BENEFITS
1. *Add a Dental Benefit to CHP+*
2. *Improve Benefits for Other CHP+ Benefits*

IV. PROGRAM EFFICIENCY AND COORDINATION
1. *Improve Coordination Between All Children's Health Programs*
2. *Reduce Administrative Costs*
3. *Move Medicaid Eligibility Determination Out Into the Communities*
4. *Maximize Federal Funding and Improve State-Federal Relations*

V. QUALITY AND ACCESS TO CARE
1. *Improve Cultural Competency*
2. *Recruit and Adequately Reimburse Providers to Improve Access to Care for Children*
3. *Adopt Child-Specific Protections and Quality Standards*

And finally, the State must address problems caused by some of the policies it pursues, such as what the imposition of monthly premiums did and the Medicaid assets test continues to impose. These policies create "unintended consequences" that are in direct opposition to other goals of the program, such as: (1) increasing the number of children covered by the program; and, (2) operating CHP+ in a fiscally responsible manner.

When such a conflict arises, the overriding goal of expanding coverage to children should be preeminent.

As policymakers proceed to take action *or inaction* on putting in place and enforcing further improvements to Colorado's Medicaid and CHP+ programs, they should ask themselves, as recommended by the Partnership for Children, one simple, elegant question: "Is it good for our children?" Any rule, regulation, standard, guideline, or contract should be able to meet that simple but critically important test.

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Common Goals and Recommendations for Improving the Health of Colo

	Improving Coverage & Child Health	Removing Access Barriers	Reducing Bureaucracy & Admin.	Maximizing Federal Funds	Eliminating "Welfare Stigma"	Imp Qua Car
I. COVERAGE AND OUTREACH						
Expand Coverage for CHP+ to 200% of Poverty	✓	✓		✓		
Change Age-Based Eligibility Rules		✓	✓			
Adopt Continuous Eligibility in Medicaid	✓	✓	✓			
Adopt Presumptive Eligibility	✓	✓				
Improve Outreach Efforts/Spend TANF Funds	✓	✓		✓	✓	
Do Not Eliminate CICP for Kids		✓				
II. ENROLLMENT BARRIERS						
Inform Public on Premium Changes	✓	✓			✓	
Eliminate Medicaid Assets Test		✓	✓		✓	
Create Single Definition of "Family Income"		✓	✓			
Simplify Application & Enrollment Processes	✓	✓	✓	✓	✓	
Simplify Redetermination	✓	✓	✓	✓	✓	
Reduce Waiting Time for Coverage	✓	✓		✓		
Reduce or Eliminate Verification &	✓	✓	✓		✓	

Documentation						
	Improving Coverage & Child Health	**Removing Access Barriers**	**Reducing Bureaucracy & Admin.**	**Maximizing Federal Funds**	**Eliminating "Welfare Stigma"**	**Imp Qua Car**
III. HEALTH BENEFITS						
Add Dental Benefit to CHP+	✓	✓		✓		
Improve Other CHP+ Benefits	✓	✓		✓		
IV. PROGRAM EFFICIENCY & COORDINATION						
Improve Coordination Between Programs	✓	✓	✓	✓	✓	
Reduce Administrative Costs	✓	✓	✓	✓	✓	
Move Medicaid Eligibility Determination		✓	✓		✓	
Maximize Federal Funding/ Improve State-Fed Relations				✓		
V. QUALITY & ACCESS TO CARE						
Improve Cultural Competence	✓	✓			✓	
Provide Adequate Payment for Providers	✓	✓				
Adopt Child-Specific Standards	✓	✓				